

Member Name: _____

MA ID # _____

Higher Level of Care Discharge Guide

Please Fax Form to VBH-814-528-0603 & Judy Martin-814-451-6859

CURRENT RISK – Check all that apply		
Member's Risk to Self: <input type="checkbox"/> 0 (None) <input type="checkbox"/> 1 (Mild or Mildly Incapacitating) <input type="checkbox"/> 2 Moderate or Moderately Incapacitating <input type="checkbox"/> 3 (Severe or Severely Incapacitating) <input type="checkbox"/> NA (Not Assessed)	Member's Risk to Others: <input type="checkbox"/> 0 (None) <input type="checkbox"/> 1 (Mild or Mildly Incapacitating) <input type="checkbox"/> 2 Moderate or Moderately Incapacitating <input type="checkbox"/> 3 (Severe or Severely Incapacitating) <input type="checkbox"/> NA (Not Assessed)	
CURRENT IMPAIRMENTS – Key:		
<input checked="" type="checkbox"/> 0 (None) <input checked="" type="checkbox"/> 1 (Mild or Mildly Incapacitating) <input checked="" type="checkbox"/> 2 (Moderate or Moderately Incapacitating) <input checked="" type="checkbox"/> 3 (Severe or Severely Incapacitating) <input checked="" type="checkbox"/> NA (Not Assessed)		
Mood Disturbances (Depression or Mania)	Weight Loss Associated with an Eating Disorder	Anxiety
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A
Medical/Physical Conditions	Psychosis/Hallucinations/Delusions	Substance Abuse/Dependence
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A
Thinking/Cognition/Memory/Concentration Problems	Job/School Performance Problems	Impulsive/Reckless/Aggressive Behavior
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A
Social Functioning Relationships/Marital/Family Problems	Activities of Daily Living Problems	Legal
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A

Agency Name:

Agency Address:

Agency Phone Number:

Name of the Lead Clinician from the Agency on the Case:

VBH CAFS Coordinator:

Discharge Date:

Final Axis I Diagnosis:

Discharge GAF:

Discharge Condition: __ Improved __ No Change __ Worse

Level Of Care Discharged to:

Discharge Plan in Place: ___ Yes ___ No

Type of Discharge: ___AMA ___ Planned

If Discharge was planned, did the Provider or Prescriber recommend follow up treatment? ___ Yes ___ No

Discharge Residence:

Members Current Phone Number:

Aftercare Follow-up: